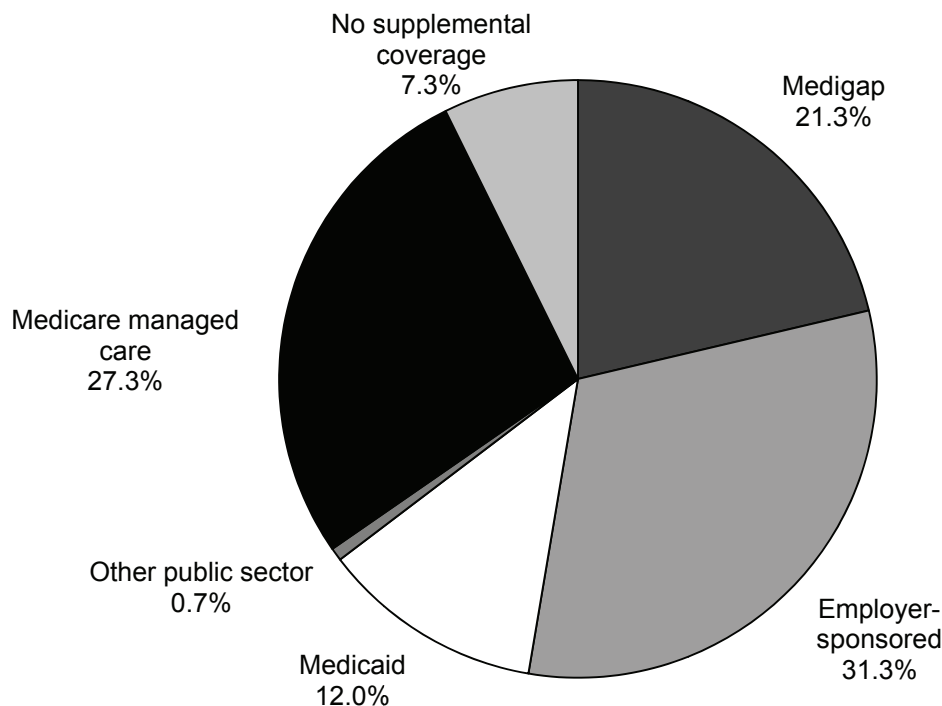


SECTION

5

Medicare beneficiary and other payer financial liability

Chart 5-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2009



Note: Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2009. They could have had coverage in other categories during 2009. "Other public sector" includes federal and state programs not included in other categories. Analysis includes only beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2009 or who had Medicare as a second payer.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2009.

- Most beneficiaries living in the community have coverage that supplements or replaces the Medicare benefit package. About 93 percent of beneficiaries have supplemental coverage or participate in Medicare managed care.
- About 53 percent have private-sector supplemental coverage such as medigap (about 21 percent) or employer-sponsored retiree coverage (about 31 percent).
- About 13 percent have public-sector supplemental coverage, primarily Medicaid.
- Twenty-seven percent participate in Medicare managed care. This care includes Medicare Advantage, cost, and health care prepayment plans. These types of arrangements generally replace Medicare's fee-for-service coverage and often add to it.

Chart 5-2. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, by beneficiaries' characteristics, 2009

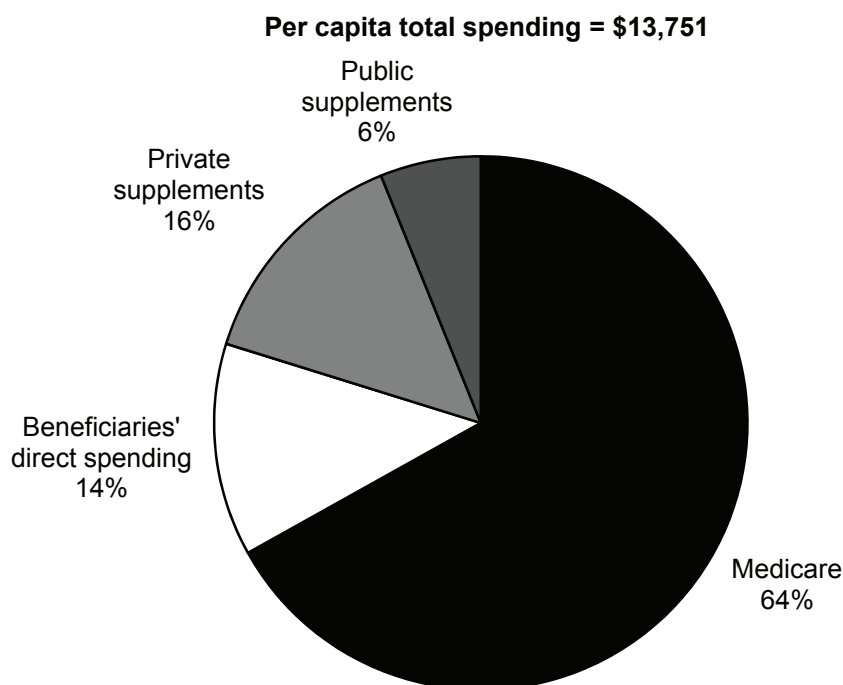
	Number of beneficiaries (thousands)	Employer- sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	40,197	31%	21%	12%	27%	1%	7%
Age							
Under 65	6,047	15	4	41	21	2	17
65–69	9,260	37	20	8	27	0	8
70–74	8,142	32	24	7	31	1	5
75–79	6,512	32	25	7	31	1	4
80–84	5,281	34	26	6	29	1	4
85+	4,954	35	29	7	24	0	4
Income status							
Below poverty	6,139	11	12	44	25	0	7
100% to 125% of poverty	3,636	12	16	29	30	1	12
125% to 200% of poverty	7,993	23	21	11	32	2	12
200% to 400% of poverty	12,565	39	24	1	29	0	6
Over 400% of poverty	9,807	48	26	1	22	0	3
Eligibility status							
Aged	33,905	34	24	7	29	1	6
Disabled	5,848	15	4	40	21	2	17
ESRD	398	17	24	43	9	1	6
Residence							
Urban	30,639	31	20	11	31	1	6
Rural	9,546	31	27	16	14	1	11
Sex							
Male	17,970	33	19	12	26	1	9
Female	22,227	30	23	12	28	1	6
Health status							
Excellent/very good	17,118	36	25	5	27	0	5
Good/fair	19,896	29	19	15	29	1	8
Poor	2,859	19	14	32	22	2	12

Note: ESRD (end-stage renal disease). Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2009. They could have had coverage in other categories during 2009. Medicare managed care includes Medicare Advantage, cost, and health care prepayment plans. "Other public sector" includes federal and state programs not included in other categories. In 2009, poverty was defined as \$10,289 for people living alone and \$12,982 for married couples. "Urban" indicates beneficiaries living in metropolitan statistical areas (MSAs). "Rural" indicates beneficiaries living outside MSAs. Analysis includes beneficiaries living in the community. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2009 or who had Medicare as a secondary payer. Number of beneficiaries differs among boldface categories because we excluded beneficiaries with missing values. Numbers may not sum due to rounding.

Source: MedPAC analysis of 2009 Medicare Current Beneficiary Survey, Cost and Use file.

- Beneficiaries most likely to have employer-sponsored supplemental coverage are those who are above age 64, are higher income (above 200 percent of poverty), are eligible due to age, and report better than poor health.
- Medigap is most common among those who are age 70 or older, are middle or higher income (above 125 percent of poverty), are eligible due to age or ESRD, are rural dwelling, are female, and report excellent or very good health.
- Medicaid coverage is most common among those who are under age 65, are low income (below 125 percent of poverty), are eligible due to disability or ESRD, are rural dwelling, and report poor health.
- Lack of supplemental coverage (Medicare coverage only) is most common among beneficiaries who are under age 65, have income below 200 percent of poverty, are eligible due to disability, are rural dwelling, are male, and report poor health.

Chart 5-3. Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2009

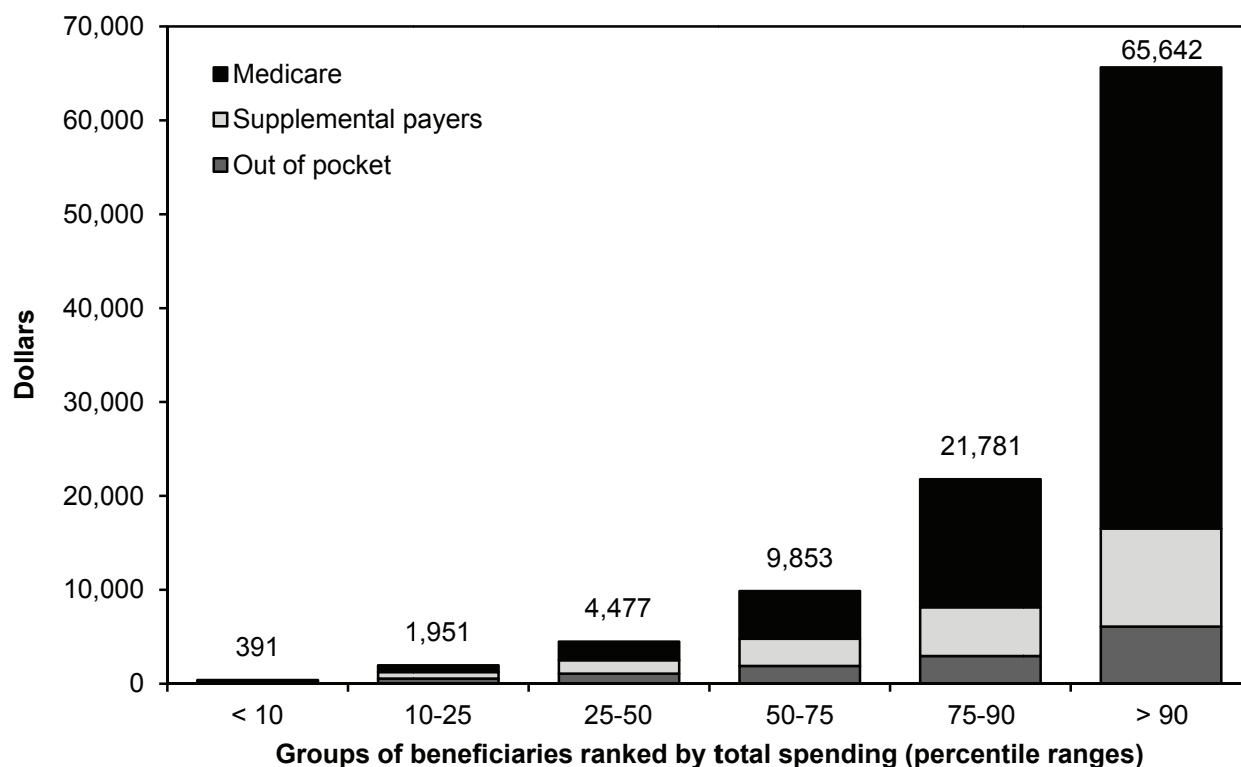


Note: FFS (fee-for-service). Private supplements include employer-sponsored plans and individually purchased coverage. Public supplements include Medicaid, Department of Veterans Affairs, and other public coverage. Direct spending is on Medicare cost sharing and noncovered services, but not supplemental premiums. Analysis includes only FFS beneficiaries not living in institutions such as nursing homes.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2009.

- Among FFS beneficiaries living in the community, the total cost of health care services (defined as beneficiaries' direct spending, as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) averaged \$13,751 in 2009. Medicare is the largest source of payment; it pays 64 percent of the health care costs for FFS beneficiaries living in the community, an average of \$8,845 per beneficiary. The level of Medicare spending in this chart differs from the level in Chart 2-1 because this chart excludes beneficiaries in Medicare Advantage and those living in institutions, while Chart 2-1 represents all Medicare beneficiaries.
- Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and medigap—paid 16 percent of beneficiaries' costs, an average of \$2,259 per beneficiary.
- Beneficiaries paid 14 percent of their health care costs out of pocket, an average of \$1,877 per beneficiary.
- Public sources of supplemental coverage—primarily Medicaid—paid 6 percent of beneficiaries' health care costs, an average of \$769 per beneficiary.

Chart 5-4. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2009

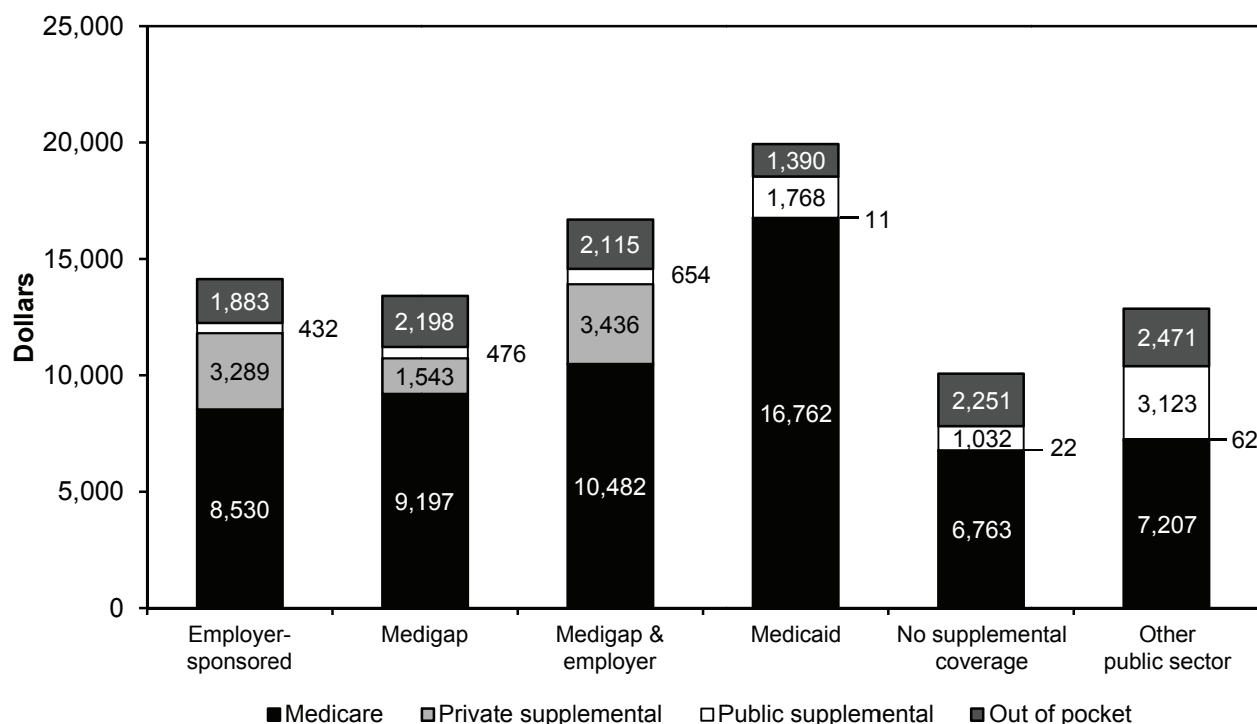


Note: FFS (fee-for-service). Analysis excludes those who are not in FFS Medicare and those living in institutions such as nursing homes. Out-of-pocket spending includes Medicare cost sharing and noncovered services.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2009.

- Total spending on health care services varies dramatically among FFS beneficiaries living in the community. Per capita spending for the 10 percent of beneficiaries with the highest total spending averages \$65,642. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averages \$391.
- Among FFS beneficiaries living in the community, Medicare pays a larger percentage as total spending increases, and beneficiaries' out-of-pocket spending is a smaller percentage as total spending increases. For example, Medicare pays 64 percent of total spending for all beneficiaries but pays 75 percent of total spending for the 10 percent of beneficiaries with the highest total spending. Beneficiaries' out-of-pocket spending covers 14 percent of total spending for all beneficiaries, but only 9 percent of total spending for the 10 percent of beneficiaries with the highest total spending.

Chart 5-5. Variation in and composition of total spending among noninstitutionalized FFS beneficiaries, by type of supplemental coverage, 2009

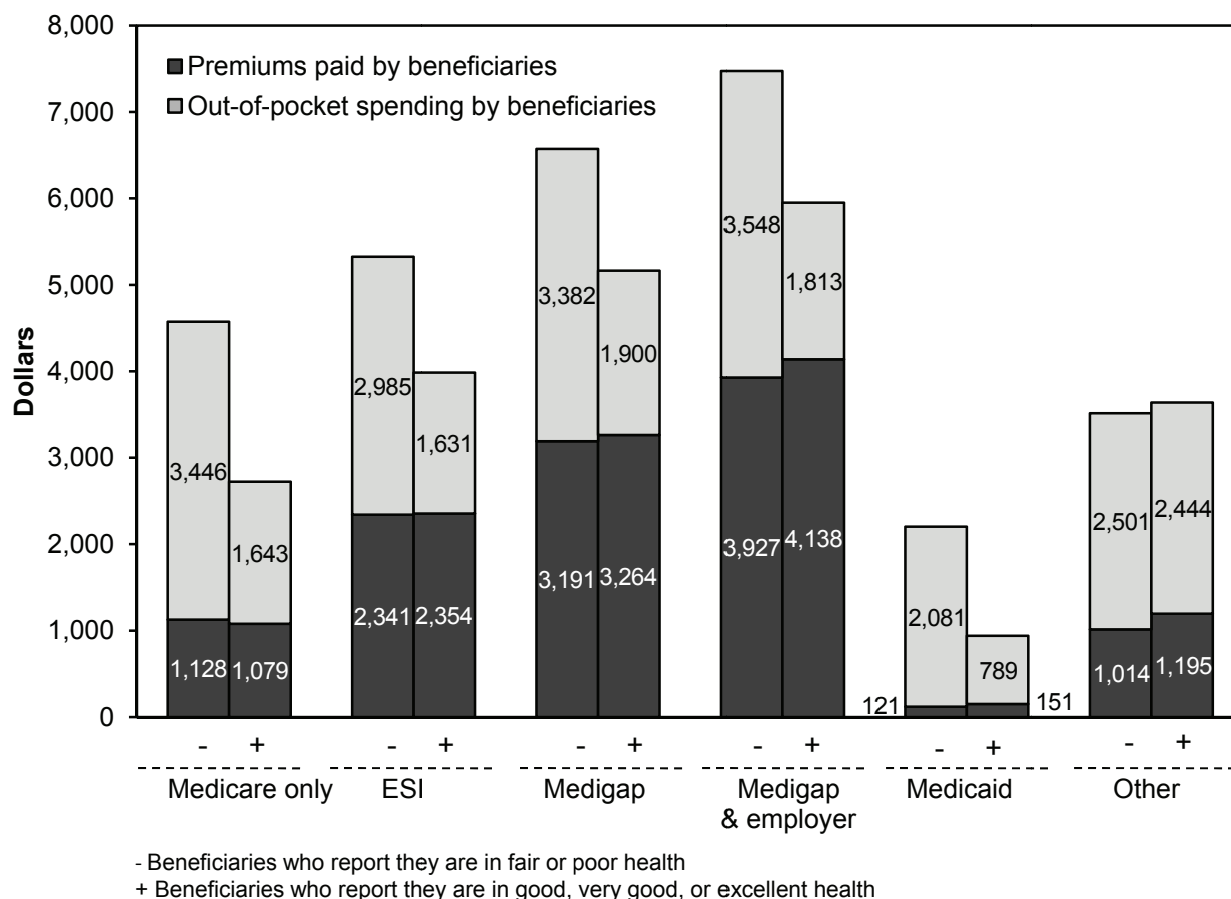


Note: FFS (fee-for-service). Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2009. They could have had coverage in other categories during 2009. "Other public sector" includes federal and state programs not included in the other categories. "Private supplemental" includes employer-sponsored plans and individually purchased coverage. "Public supplemental" includes Medicaid, Department of Veterans Affairs, and other public coverage. Analysis excludes beneficiaries who are not in FFS Medicare or live in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2009 or had Medicare as a second payer. Out-of-pocket spending includes Medicare cost sharing and noncovered services, but not supplemental premiums.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2009

- The level of total spending (defined as beneficiaries' out-of-pocket spending, as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) among FFS beneficiaries living in the community varies by the type of supplemental coverage they have. Total spending is much lower for those beneficiaries with no supplemental coverage than for those beneficiaries who have supplemental coverage. Beneficiaries with Medicaid coverage have the highest level of total spending, 98 percent higher than those with no supplemental coverage.
- Medicare is the largest source of payment for beneficiaries in each supplemental insurance category, but the second largest source of payment differs. Among those with employer-sponsored, medigap plus employer, Medicaid, and other public, supplemental coverage coverage—public and private combined—is the second largest source of payment. Among those who have only medigap, supplemental coverage and out of pocket are about equal. Among those who have Medicare-only coverage, beneficiaries' out-of-pocket spending is the second largest source of payment.

Chart 5-6. Out-of-pocket spending for premiums and health services per beneficiary, by insurance and health status, 2009



Note: ESI (employer-sponsored supplemental insurance).

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2009.

- This diagram illustrates out-of-pocket spending on services and premiums by beneficiaries' supplemental insurance and health status. For example, beneficiaries who have only traditional Medicare coverage (Medicare only) and report fair or poor health had an average of \$1,128 in out-of-pocket spending on premiums and \$3,446 on services. Those who have Medicare-only coverage and report good, very good, or excellent health had an average of \$1,079 in out-of-pocket spending on premiums and \$1,643 on services.
- Insurance that supplements Medicare does not shield beneficiaries from all out-of-pocket costs. Beneficiaries who report being in fair or poor health spend more out of pocket for health services than those reporting good, very good, or excellent health regardless of the type of coverage they have to supplement Medicare.
- Despite having supplemental coverage, beneficiaries who have ESI or medigap have out-of-pocket spending that is comparable to or more than those who have only coverage under traditional Medicare (Medicare only). This result likely reflects the fact that beneficiaries who have ESI or medigap have higher incomes and are likely to have stronger preferences for health care.
- What beneficiaries actually pay out of pocket varies by type of supplemental coverage. For those with medigap, out-of-pocket spending generally reflects the premiums and costs of services not covered by Medicare. Beneficiaries with ESI usually pay less out of pocket for Medicare noncovered services than those with medigap, but may pay more in Medicare deductibles and cost sharing.

Web links. Medicare beneficiary and other payer financial liability

- Chapter 1 of the MedPAC March 2012 Report to the Congress provides more information on Medicare program spending.

http://www.medpac.gov/chapters/Mar12_ch01.pdf

- Chapter 1 of the MedPAC March 2011 Report to the Congress provides more information on Medicare program spending.

http://www.medpac.gov/chapters/Mar11_ch01.pdf

- Chapter 1 of the MedPAC March 2010 Report to the Congress provides more information on Medicare program spending.

http://www.medpac.gov/chapters/Mar10_ch01.pdf

- Chapter 1 of the MedPAC June 2012 Report to the Congress discusses benefit design in fee-for-service Medicare.

http://www.medpac.gov/chapters/Jun12_ch01.pdf

- Chapter 3 of the MedPAC June 2011 Report to the Congress discusses beneficiaries' supplemental coverage, cost sharing, and health care use, as well as program spending.

http://medpac.gov/chapters/Jun11_ch03.pdf

- Chapter 2 of the MedPAC June 2010 Report to the Congress discusses the effect supplemental coverage has on beneficiaries' cost sharing, their health care use, and program spending.

http://www.medpac.gov/chapters/Jun10_ch02.pdf

- Appendix B of the MedPAC June 2004 Report to the Congress and Chapter 1 of the MedPAC June 2002 Report to the Congress provide more information on Medicare beneficiary and other payer financial liability.

http://www.medpac.gov/publications/congressional_reports/June04_AppB.pdf

http://www.medpac.gov/publications/congressional_reports/Jun2_Ch1.pdf

